STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to follow its abuse policy related to prevention of potential abuse and reporting of abuse allegations for two (R2, R5) out of twelve residents reviewed for abuse. This failure had the potential to affect all 163 residents residing in the facility.The findings include: 1.R2's face sheet / admission record shows initial admit date on 12/4/17, with diagnoses not limited to Type 2 diabetes mellitus with diabetic neuropathy, Hypertensive heart disease, Primary osteoarthritis, Hypothyroidism, Major depressive disorder, Unspecified dementia, Anxiety disorder, Insomnia, Gastro-esophageal reflux disease, Hyperlipidemia. MDS (Minimum Data Set), dated 3/13/26, shows R2's cognition is moderately impaired. On 4/21/26 At 11:12 AM, R2 was alert and verbally responsive, Spanish speaking, and able to speak and understand simple English. Requested V28 (Housekeeping) in R2's room as a Spanish speaking interpreter. R2 stated 2 ladies (Certified Nursing Assistants/CNAs) pulled / pushed her into the bathroom and she fell on the floor. R2 stated she was lying on the floor. She does not know the names of the staff, but she said they were African - American. R2 stated the incident happened on Sunday (4/12/26) morning. She stated she hit her head on the wall, and she hit her right arm on the floor and had bruises. R2 showed her right thigh to surveyor and observed with purplish / greenish discoloration on right thigh. She stated another staff member came in and helped her with the 2 CNAs to get up from the floor to her bed. She stated she was transferred to the hospital and was admitted for about 4-5 days. R2 stated she saw the 2 CNAs working in the facility after the incident. She stated she feels safe now. R2 stated she felt abused when the 2 CNAs pushed her and fell on the floor. R2 stated she can ambulate with cane by herself. R2's Nurses Notes, dated 4/12/26, shows: R2 fell at approximately 8:30AM. When R2 was asked what happened, R2 stated, I was pushed to the floor by CNA. Notified the administrator immediately. R2 was transferred to the hospital for medical evaluation. On 4/21/26 At 2:02PM, V17 (LPN / Licensed Practical Nurse) stated she had not seen abuse or staff pushing to cause harm to residents in the facility. V17 stated on 4/12/26, she heard a resident screaming / crying, and she went to R2's room right away. She stated she saw R2 in the bathroom in a sitting position on the floor. V17 stated R2 claimed she was pushed to the floor, referring to 2 CNAs (V19 and V39); both CNAs were not close to R2. V17 stated they assisted R2 back to bed with 2 CNAs. She said there was a bump on the right side of her head. R2 claimed she hit the wall. V17 stated she informed nurse assigned to R2 (V16) to follow up immediately. She said R2 was able to get up from sitting to standing position with assistance from V17 and 2 CNAs (V19 and V39). She stated R2 was able to ambulate from bathroom to her bed with supervision. V17 stated she was informed by V16 that she reported R2's claim of the pushing incident to (V1) administrator because it was physical abuse allegation. V17 stated the 2 CNAs were denying R2 was pushed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 4/21/26 AT 2:26PM, V19 (CNA / Certified Nursing Assistant) stated on 4/12/26 around 8-9AM, she was passing breakfast trays to residents and saw R2 trying to feed her roommate. She stated V39 (assigned CNA) attempted to redirect R2 but R2 was not listening to V39. V19 stated she intervened and went inside the room and asked R2 if she wanted to go to bathroom to redirect her and R2 agreed. She stated R2 was ambulatory with no device, was wearing proper footwear. V19 stated she held the bathroom door open for her to go in. V19 stated R2 was saying racial slur Ni**er, Bi**h. V19 stated she stayed quiet, and she kept holding the bathroom door. V19 stated R2 then turned around and punched her on the face. V19 stated she tried to back up and R2 attempted to strike again. She stated she tried to remove herself from the situation but there was no space to back up. V19 stated she was trying to hold R2's hand to stop striking or hitting but could not hold R2. V19 stated R2 then lost her balance by snatching back from her and landed on the floor. V19 stated she did not push R2, and she did not have physical contact with R2. She stated they (V19 and V39) were not close to R2. V19 stated V17 (nurse) came to assess R2, who was aggressive. She stated R2 had a bump on the head and bruise on right elbow. V19 stated she did not see R2 hit her head on the door or any surface. She hit her elbow on the floor when she fell. V19 stated they assisted R2 from sitting to standing position, physically assisted R2 to walk to her bed. V19 stated when R2 was in bed, she was claiming she was pushed by 2 CNAs (V19 and V39). She stated R2 allowed her to assist her walking back to her bed. She stated R2 was not scared but she was upset because she fell and R2 was yelling. V19 said she was not suspended or was not sent home. V19 stated V38 (Manager on duty) was aware of the incident. She stated R2 was transferred to the hospital. V19 stated she was not suspended. She was not sent home, and she continued to work on the 4th floor caring for the residents. She said their Abuse Coordinator is the Administrator (V1) who was made aware of the incident and the claim of R2 that she was pushed. V19 stated pushing is an example of physical abuse. It was an abuse allegation because R2 claimed that she was pushed. V19 stated there was no pushing that happened between staff and R2. On 4/21/26 At 3PM, V39, (CNA / Certified Nursing Assistant), stated on 4/12/26 around 8:30AM, breakfast time, R2 was in the room and attempting to feed the roommate. She stated she was trying to redirect R2 and was not responding after redirection. She said V19 (CNA) walked into the room and redirected R2 to go to the bathroom. V19 opened the bathroom door, R2 refused to use assistive device – cane or walker. She stated R2 was calling out Ni**er, bi**h, turned around and punched V19 on the face. She said R2 snatched back, and she lost her balance and landed on the floor. V39 stated there was no pushing happened; they never had physical contact with R2. V39 stated she called the nurse right away. She stated R2's claim of pushing is an example physical abuse allegation. She stated it was reported to the Administrator who is the Abuse Coordinator. V39 stated she was not sent home or suspended; she was not removed from residents' care area. She continued to work with R2 and the rest of the residents assigned to her. On 4/21/26 At 3:25PM, V16 (LPN / Licensed Practical Nurse) stated she received an abuse allegation. R2 claimed CNAs (V19 and V39) pushed her to the floor. She stated there was a bump on the right side of the head. V16 stated she reported the incident right away to V1 (Administrator) who is the Abuse Coordinator and R2 was transferred to the hospital. V16 stated pushing is a suspected abuse. She said V39 (CNA) continued to work with R2. V16 stated R2 claimed V39 pushed R2. She stated V39 continued working with the residents on the 4th floor. On 4/21/26 at 3:45PM, V38 (Guest relation and Activity Director) stated she was the MOD (Manager on Duty) on 4/12/26, doing rounds to the 4th floor, and there were 4 staff in R2's room, 2 CNAs and 2 nurses. V38 stated she went inside the room, R2 is Spanish speaking so she requested housekeeper - Spanish interpreter. V38 stated R2 claimed that she was pushed and fell on the floor. V38 there was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	situation with R2 and the 2 CNAs. R2 was using inappropriate words Ni**er bi**h swinging at the CNA, lost her balance and fell on the floor. She stated V1, who is the Abuse Coordinator, was informed about the incident as it was an abuse allegation, staff were requested to write a statement. V38 stated V1 came to the facility to investigate the incident. She stated R2 was transferred to the hospital. V19 and V39 continued to work with residents on the 4th floor, they were not suspended, they were not removed from residents' care area. On 4/23/26 at 9:45AM, V1 (Administrator) stated he has been working in the facility for 2 years in the facility and he is the Abuse Coordinator. He stated if there is an abuse allegation involving staff, suspend staff pending investigation or removed from resident's care area immediately to keep resident safe. V1 stated the goal of the facility is for all residents to be free from abuse. He stated an example of physical abuse is hitting or intentional pushing. He stated R2 had a fall incident on 4/12/26; R2 was attempting to feed her roommate. V19 and V39 attempted to redirect R2, and she became aggressive. R2 attempted to strike V19, R2 pulled her arm away, and that's how R2 fell. V1 stated R2's son came to the facility and claimed that somebody hit his mom. V1 stated any abuse allegation should be reported to the State Agency within 2 hours and final report should be within 5 business days. V1 stated the purpose of reporting to the State Agency to make sure facility follows regulations. He stated he was not aware of R2's claim that she was pushed to the floor by V19 and V39 and the allegation was not reported to the State Agency. On 4/23/26 at 11:08AM, V2 (DON / Director of Nursing) stated their Abuse Coordinator is the Administrator and she is the designee when V1 is not around in the facility. She stated if there an abuse allegation involving the staff – suspend pending investigation or remove staff from residents' care area to keep resident safe or prevent possible abuse. She said an example of physical abuse is hitting or intentional pushing. V2 stated their goal is for all residents be free from abuse. She stated if there is an abuse allegation, it should be initially reported to the State Agency within 2 hours, and final report should be submitted in 5 days. V2 stated an abuse allegation is reported to the State Agency to make agency aware of the alleged abuse. Reviewed R2's EHR (Electronic Health Record) with V2 and read nurse's notes on 4/12/26: R2 stated, I was pushed to the floor by CNA. V2 stated R2 claiming she was pushed is an alleged physical abuse and should be reported to the State Agency. Facility's reportable for the month of April 2026, no abuse allegation reports for R2 submitted to IDPH (Illinois Department of Public Health). 2.R5's Minimum Data Set (MDS) assessment, dated 10/27/25, shows a BIMS (Brief Interview for Mental Status) of 15, which means R5 is cognitively intact. R5's comprehensive care plan does not include an individualized plan of care related to potential abuse. Initial abuse reportable sent to IDPH on 4/21/26 at 2:58 PM; date and time of incident 4/7/26 at 5:00 AM. On 4/21/26 at 11:34 AM, R5 stated there is a nurse [V45 (Licensed Practical Nurse/LPN] who works night shift on weekends. R5 stated after she had fallen onto the floor mattress beside the bed, she pressed the call light, V45 entered her room and kicked her in the lower back while telling her to get up. R5 stated the incident occurred around 1:00 AM. R5 stated no one witnessed the alleged incident because she was alone at the time with V45. R5 stated other staff later came into the room, including two male CNAs [Certified Nursing Assistants] and one female CNA. R5 stated she informed the male CNA that V45 had kicked her on her back. R5 does not remember the name of the CNA. R5 stated she also spoke with V1 [Administrator] that morning and informed him that V45 had kicked her. R5 stated V45 no longer comes to her room. R5 believed the incident occurred a couple of weeks earlier, possibly at the beginning of April. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 4/21/26 at 1:18 PM, V1 (Administrator) stated R5's allegation was not reported to IDPH [Illinois Department of Public Health] because he determined it was not abuse. V1 stated R5 reported she fell to the floor and staff came to assist her back into bed. V1 stated R5 mentioned kicking, but when V1 asked for clarification, R5 stated there was a pack of diapers on the floor because she was between the window area. V1 stated R5 then stated V45 kicked the diaper pack to the side. V1 stated nothing was mentioned about V45 kicking R5. V1 denied a police report was done. V1 stated per facility's abuse prevention policy, if a staff member had kicked a resident, V1 would report the allegation to IDPH, investigate it, and suspend the staff member pending the investigation to protect all residents. V1 stated V45 was not suspended because the allegation was not substantiated. V1 stated R5 had a care plan related to making false allegations and described her as drug seeking. V1 stated the facility's abuse policy is that abuse allegations must be reported immediately. V1 stated an initial report is completed within two hours, followed by a thorough investigation that includes interviews with staff and residents. V1 stated the final report is completed within five days. V1 stated he is the abuse coordinator and expects staff to report allegations to him immediately. V1 stated abuse in-service training is completed at least quarterly, as well as web-based and skills training. On 4/22/26 at 9:25 AM, a phone interview was conducted with V44 (Certified Nursing Assistant/CNA). V44 stated he was the CNA assigned for R5 at the time of the incident, but does not remember the exact date. V44 stated it was at the beginning of April. V44 stated between 1:00 AM to 2:00 AM, R5 was heard screaming for help and V44 observed R5 on the floor. V44 stated he notified V45 and two other CNAs. V44 stated they responded together and assisted R5. V44 stated he was present the entire time with V45 and stated V45 did not kick R5. V44 stated hours later, R5 claimed she had been kicked by V45, but V44 stated this did not occur. V44 stated the first time he became aware of R5's allegation was around 5:30 AM. V44 stated he went to R5's room to ensure she was okay and R5 stated she was calling the police and claimed V45 had kicked her. V44 stated he informed V45 of R5's allegation. V44 stated he later spoke with V1 after his shift, possibly around 8:00 AM. V44 stated V1 contacted him because police involvement had been mentioned by R5 and wanted to know what happened. V44 stated V1 said R5 reported that V45 had kicked her. V44 stated he explained the events as previously described to V1. V44 stated V1 called him again the previous day to ask whether anything in his statement had changed or whether he had additional information. On 4/22/26 at 9:56 AM, a phone interview was conducted with V45 (Licensed Practical Nurse). V45 stated she had never been suspended or sent home because of an abuse allegation. V45 stated she cared for R5 on the night the resident was found on the floor after stating she had fallen. V45 did not remember the exact date but believed it was at the beginning of April. V45 stated she was working with three other staff members that night [V44 and V46 (CNA)]. V45 stated she went home after the shift and did not receive any report about R5's abuse allegation. V45 stated the following day, V1 called and told her R5 reported that V45 had kicked her. V45 stated she was not told about the kicking allegation until the following day when V1 called V45. V45 denied ever kicking R5. V45 stated she was R5's nurse until 7:00 AM, when the next shift nurse arrived. V45 stated V1 did not suspend her pending investigation because V1 spoke with the staff and determined the allegation did not happen. V45 stated V1 documented the matter as a concern because the allegation of physical abuse was not substantiated. V45 stated she was told not to care for R5, but V45 continued to work on the same floor. The facility's residents' roster, dated 4/21/26, shows a total of 163 residents residing in the facility. Facility's Abuse and Retaliation Policy prevention program, dated 1/2026, shows: Employee of this facility who have been accused of abuse will be removed from resident contact immediately. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator, and it is determined that any allegation of abuse is unsubstantiated. Any incident or allegation involving abuse will result in investigation. When an allegation of abuse has been made, the administrator or designee, shall notify the Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse has been reported to the administrator and is being investigated. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to follow their policy to notify Department of Public Health regional office for an abuse allegation for two (R2 and R5) out of 12 residents reviewed for abuse. 1.R2's face sheet / admission record shows initial admit date on 12/4/17, with diagnoses not limited to Type 2 diabetes mellitus with diabetic neuropathy, Hypertensive heart disease, Primary osteoarthritis, Hypothyroidism, Major depressive disorder, Unspecified dementia, Anxiety disorder, Insomnia, Gastro-esophageal reflux disease, Hyperlipidemia. MDS (Minimum Data Set) dated 3/13/26 shows R2's cognition is moderately impaired. On 4/21/26 At 11:12 AM, R2 was alert and verbally responsive, Spanish speaking, and able to speak and understand simple English. Requested V28 (Housekeeping) in R2's room as a Spanish speaking interpreter. R2 stated 2 ladies (CNAs) pulled / pushed her into the bathroom and she fell on the floor. R2 stated she was lying on the floor. She does not know the names of the staff, but she said they were African - American. R2 stated the incident happened on Sunday (4/12/26) morning. She stated she hit her head on the wall, and she hit her right arm on the floor and had bruises. R2 showed her right thigh to surveyor and observed with purplish / greenish discoloration on right thigh. She stated another staff member came in and helped her with the 2 CNAs to get up from the floor to her bed. She stated she was transferred to the hospital and was admitted for about 4-5 days. R2 stated she saw the 2 CNAs working in the facility after the incident. She stated she feels safe now. R2 stated she felt abused when the 2 CNAs pushed her and fell on the floor. R2 stated she can ambulate with cane by herself. R2's Nurses Notes, dated 4/12/26, shows: R2 fell at approximately 8:30AM. When R2 was asked what happened, R2 stated I was pushed to the floor by CNA. Notified the administrator immediately. R2 was transferred to the hospital for medical evaluation. On 4/21/26 at 2:02PM, V17 (LPN / Licensed Practical Nurse) she stated she had not seen abuse or staff pushing to cause harm to residents in the facility. V17 stated on 4/12/26, she heard a resident screaming / crying, and she went to R2's room right away. She stated she saw R2 in the bathroom in a sitting position on the floor. V17 stated R2 claimed that she was pushed to the floor referring to 2 CNAs (V19 and V39), both CNAs were not close to R2. V17 stated they assisted R2 back to bed with 2 CNAs. She said there was a bump on the right side of her head; R2 claimed she hit the wall. V17 stated she informed the nurse assigned to R2 (V16) to follow up immediately. She said R2 was able to get up from sitting to standing position with assistance from V17 and 2 CNAs (V19 and V39). She stated R2 was able to ambulate from bathroom to her bed with supervision. V17 stated she was informed by V16 that she reported R2's claim of the pushing incident to (V1) Administrator because it was physical abuse allegation. V17 stated the 2 CNAs were denying R2 was pushed. On 4/21/26 at 2:26PM, V19 (CNA / Certified Nursing Assistant) stated on 4/12/26 around 8-9AM, she was passing breakfast trays to residents and saw R2 trying to feed her roommate. She stated V39 (assigned CNA) attempted to redirect R2 but R2 was not listening to V39. V19 stated she intervened and went inside the room and asked R2 if she wanted to go to the bathroom to redirect her and R2 agreed. She stated R2 is ambulatory with no device, was wearing proper footwear. V19 stated she held the bathroom door open for her to go in. V19 stated R2 was saying racial slur Ni**er, Bi**h. V19 stated she stayed quiet, and she kept holding the bathroom door. V19 stated R2 then turned around and punched her on the face. V19 stated she tried to back up and R2 attempted to strike again. She stated she tried to remove herself from the situation but there was no space to back up. V19 stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was trying to hold R2's hand to stop striking or hitting but could not hold R2. V19 stated R2 then lost her balance by snatching back from her and landed on the floor. V19 stated she did not push R2, and she did not have physical contact with R2. She stated they (V19 and V39) were not close to R2. V19 stated V17 (nurse) came to assess R2 who was aggressive. She stated R2 had a bump on the head and bruise on right elbow. V19 stated she did not see R2 hit her head on the door or any surface. She hit her elbow on the floor when she fell. V19 stated they assisted R2 from sitting to standing position, physically assisted R2 to walk to her bed. V19 stated when R2 was in bed, she was claiming that she was pushed by 2 CNAs (V19 and V39). She stated R2 allowed her to assist her walking back to her bed. She stated R2 was not scared but she was upset because she fell and R2 was yelling. V19 said she was not suspended or was not sent home. V19 stated V38 (Manager on duty) was aware of the incident. She stated R2 was transferred to the hospital. V19 stated she was not suspended. She was not sent home, and she continued to work on the 4th floor caring for the residents. She said their abuse coordinator is the Administrator (V1) who was made aware of the incident and the claim of R2 that she was pushed. V19 stated pushing is an example of physical abuse. It was an abuse allegation because R2 claimed that she was pushed. V19 stated there was no pushing that happened between staff and R2. On 4/21/26 at 3PM, V39 (CNA / Certified Nursing Assistant) stated on 4/12/26 around 8:30AM, breakfast time, R2 was in the room and attempting to feed the roommate. She stated she was trying to redirect R2 and was not responding after redirection. She said V19 (CNA) walks into the room and redirected R2 to go bathroom. V19 opened the bathroom door, R2 refused to use assistive device – cane or walker. She stated R2 was calling out Ni**er, bi**h, turned around and punch V19 on the face. She said R2 snatched back, and she lost her balance and landed on the floor. V39 stated there was no pushing happened, they never had physical contact with R2. V39 stated she called the nurse right away. She stated R2's claim of pushing is an example physical abuse allegation. She stated it was reported to the administrator who is the abuse coordinator. V39 stated she was not sent home or suspended; she was not removed from residents' care area. She continued to work with R2 and the rest of the residents assigned to her. On 4/21/26 at 3:25PM, V16 (LPN / Licensed Practical Nurse) stated she received an abuse allegation. R2 claimed that CNAs (V19 and V39) pushed her to the floor. She stated there was a bump on the right side of the head. V16 stated she reported the incident right away to V1 (Administrator) who is the Abuse Coordinator and R2 was transferred to the hospital. V16 stated pushing is a suspected abuse. She said V39 (CNA) continued to work with R2. V16 stated R2 claimed that V39 pushed R2. She stated V39 continued working with the residents on the 4th floor. On 4/21/26 3:45PM, V38 (Guest relation and Activity Director) stated she was the MOD (Manager on Duty) on 4/12/26, doing rounds to the 4th floor and there were 4 staff in R2's room, 2 CNAs and 2 nurses. V38 stated she went inside the room, R2 is Spanish speaking, so she requested housekeeper - Spanish interpreter. V38 stated R2 claimed she was pushed and fell on the floor. V38 there was situation with R2 and the 2 CNAs. R2 was using inappropriate words Ni**er bi**h swinging at the CNA, lost her balance and fell on the floor. She stated V1, who is the Abuse Coordinator, was informed about the incident as it was an abuse allegation, staff were requested to write a statement. V38 stated V1 came to the facility to investigate the incident. She stated R2 was transferred to the hospital. V19 and V39 continued to work with residents on the 4th floor, they were not suspended, they were not removed from residents' care area. On 4/23/26 at 9:45AM, V1 (Administrator) stated he has been working in the facility for 2 years in the facility and he is the Abuse Coordinator. He stated if there is an abuse allegation involving staff, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspend staff pending investigation or removed from resident's care area immediately to keep resident safe. V1 stated the goal of the facility is for all residents to be free from abuse. He stated an example of physical abuse is hitting or intentional pushing. He stated R2 had a fall incident on 4/12/26, R2 was attempting to feed her roommate, V19 and V39 attempted to redirect R2, and she became aggressive. R2 attempted to strike V19, R2 pulled her arm away, and that's how R2 fell. V1 stated R2's son came to the facility and claimed that somebody hit his mom. V1 stated any abuse allegation should be reported to the State Agency within 2 hours and final report should be within 5 business days. V1 stated the purpose of reporting to the State Agency to make sure facility follows regulations. He stated he was not aware of R2's claim that she was pushed to the floor by V19 and V39 and the allegation was not reported to the State Agency. On 4/23/26 at 11:08AM, V2, (DON / Director of Nursing), stated their Abuse Coordinator is the Administrator and she is the designee when V1 is not around in the facility. She stated if there an abuse allegation involving the staff – suspend pending investigation or remove staff from residents' care area to keep resident safe or prevent possible abuse. She said an example of physical abuse is hitting or intentional pushing. V2 stated their goal is for all residents be free from abuse. She stated if there is an abuse allegation, it should be initially reported to the State Agency within 2 hours, and final report should be submitted in 5 days. V2 stated an abuse allegation is reported to the State Agency to make agency aware of the alleged abuse. Reviewed R2's EHR (Electronic Health Record) with V2 and read nurse's notes on 4/12/26: R2 stated, I was pushed to the floor by CNA. V2 stated R2 claimed she was pushed is an alleged physical abuse and should be reported to state agency. Facility's reportable for the month of April 2026 showed no abuse allegation reports for R2 submitted to IDPH (Illinois Department of Public Health). Facility's Abuse and Retaliation Policy prevention program, dated 1/2026, shows: Employee of this facility who have been accused of abuse will be removed from resident contact immediately. The employee shall not be permitted to return to work until the results of the investigation have been reviewed by the administrator, and it is determined that any allegation of abuse is unsubstantiated. Any incident or allegation involving abuse will result in investigation. When an allegation of abuse has been made, the administrator or designee, shall notify the Department of Public Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse has been reported to the administrator and is being investigated. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. 2.R5's Minimum Data Set (MDS) assessment, dated 10/27/25, shows a BIMS (Brief Interview for Mental Status) of 15, which means R5 is cognitively intact. R5's comprehensive care plan does not include an individualized plan of care related to potential abuse. Initial abuse reportable sent to IDPH on 4/21/26 at 2:58 PM; date and time of incident 4/7/26 at 5:00 AM. On 4/21/26 at 11:34 AM, R5 stated there is a nurse [V45 (Licensed Practical Nurse/LPN] who works night shift on weekends. R5 stated that after she had fallen onto the floor mattress beside the bed, she pressed the call light, V45 entered her room and kicked her in the lower back while telling her to get up. R5 stated the incident occurred around 1:00 AM. R5 stated no one witnessed the alleged incident because she was alone at the time with V45. R5 stated other staff later came into the room, including two male CNAs [Certified Nursing Assistants] and one female CNA. R5 stated she informed the male CNA that V45 had kicked her on her back. R5 does not remember the name of the CNA. R5 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she also spoke with V1 [Administrator] that morning and informed him V45 had kicked her. R5 stated [V45] no longer comes to her room. R5 believed the incident occurred a couple of weeks earlier, possibly at the beginning of April. On 4/21/26 at 1:18 PM, V1 (Administrator) stated R5's allegation was not reported to IDPH [Illinois Department of Public Health] because he determined it was not abuse. V1 stated R5 reported she fell to the floor and staff came to assist her back into bed. V1 stated R5 mentioned kicking, but when V1 asked for clarification. R5 stated there was a pack of diapers on the floor because she was between the window area. V1 stated R5 then stated V45 kicked the diaper pack to the side. V1 stated nothing was mentioned about V45 kicking R5. V1 denied a police report was done. V1 stated per facility's abuse prevention policy, if a staff member had kicked a resident, V1 would report the allegation to IDPH, investigate it, and suspend the staff member pending the investigation to protect all residents. V1 stated V45 was not suspended because the allegation was not substantiated. V1 stated R5 had a care plan related to making false allegations and described her as drug seeking. V1 stated the facility's abuse policy is that abuse allegations must be reported immediately. V1 stated an initial report is completed within two hours, followed by a thorough investigation that includes interviews with staff and residents. V1 stated the final report is completed within five days. V1 stated he is the abuse coordinator and expects staff to report allegations to him immediately. V1 stated abuse in-service training is completed at least quarterly, as well as web-based and skills training. On 4/22/26 at 9:25 AM, a phone interview was conducted with V44 (Certified Nursing Assistant/CNA). V44 stated he was the CNA assigned for R5 at the time of the incident, but does not remember the exact date. V44 stated it was at the beginning of April. V44 stated between 1:00 AM to 2:00 AM, R5 was heard screaming for help and V44 observed R5 on the floor. V44 stated he notified V45 and two other CNAs. V44 stated they responded together and assisted R5. V44 stated he was present the entire time with V45 and stated V45 did not kick R5. V44 stated hours later, R5 claimed she had been kicked by V45, but V44 stated this did not occur. V44 stated the first time he became aware of R5's allegation was around 5:30 AM. V44 stated he went to R5's room to ensure she was okay and R5 stated she was calling the police and claimed V45 had kicked her. V44 stated he informed V45 of R5's allegation. V44 stated he later spoke with V1 after his shift, possibly around 8:00 AM. V44 stated V1 contacted him because police involvement had been mentioned by R5 and wanted to know what happened. V44 stated V1 said R5 reported that V45 had kicked her. V44 stated he explained the events as previously described to V1. V44 stated V1 called him again the previous day to ask whether anything in his statement had changed or whether he had additional information. On 4/22/26 at 9:56 AM, a phone interview was conducted with V45 (Licensed Practical Nurse). V45 stated she cared for R5 on the night the resident was found on the floor after stating she had fallen. V45 did not remember the exact date but believed it was at the beginning of April. V45 stated she was working with three other staff members that night [V44 and V46 (CNA)]. V45 stated she went home after the shift and did not receive any report about R5's abuse allegation. V45 stated the following day, [V1] called and told her that R5 reported [V45] had kicked her. V45 stated V1 reviewed the camera footage. V45 stated the incident happened around 1:00 AM and R5 was having behaviors. V45 stated a second incident occurred around 5:00 AM when staff again found R5 on the floor. V45 stated she was not told about the kicking allegation until the following day when V1 called V45. V45 denied ever kicking R5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145484	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Chicago North	2451 West Touhy Avenue Chicago, IL 60645

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure accurate medication administration by failing to verify the correct insulin dose prior to administration for one (R5) of three residents reviewed for medication administration.Findings Include:R5's clinical records show an admission date of 10/10/25. R5's order summary report, dated 4/21/26, reads: Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 12 unit subcutaneously one time only for DM [Diabetes Mellitus] for 1 Day. R5's progress notes dated 4/21/26 at 12:09 PM reads in part: [R5] blood sugar was checked-460, [V74] notified, ordered to give one time dose of 12 unit of insulin lispro. R5's care plan documents in part: (Date initiated 10/29/25) R5 has Diabetes Mellitus, on insulin. Diabetes medication as ordered by doctor.On 4/21/26 at 11:51 AM, a medication administration observation was conducted with V15 (Licensed Practical Nurse). V15 obtained R5's blood glucose reading of 460 and contacted V74 (Nurse Practitioner), who ordered Lispro insulin 12 units. At 12:05 PM, V15 prepared the insulin and presented it to V72 (Assistant Director of Nursing) for verification. V15 also showed the syringe to the surveyor. There were 13 units of insulin in the syringe. V15 then entered R5's room and was about to administer the insulin to R5. V15 and V72 were asked to recheck the dose in the syringe. V72 re-verified the syringe and removed 1 unit of insulin, correcting the dose to the ordered 12 units.On 4/21/26 at 2:05 PM, V2 (Director of Nursing) V2 stated insulin is a significant medication because it can cause adverse reactions. V2 stated if insulin is given improperly, the resident may become hypoglycemic or hyperglycemic. V2 stated hypoglycemia means a low blood sugar level from the resident's baseline. V2 emphasized the importance of following physician orders when administering medication to prevent adverse reactions. V2 stated after medication administration, the nurse documents in the MAR (Medication Administration Record) that the medication was given.The facility's INJECTABLE MEDICATION ADMINISTRATION policy reads: To administer medications via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner.